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Care through competition: The case of the Netherlands

Hasna Ashraf [*]

Abstract

The Netherlands has managed to achieve rather remarkable outcomes in terms of health, financial protection and customer satisfaction through a private-first health system, an architecture reinforced by its landmark Health Insurance Act of 2006. 16 years into the reform, this paper looks at what factors led to the transition to managed competition and to what extent the Dutch system stays true to Enthoven's theoretical principles of managed competition. We find that while there are deviations from the theoretical model in how managed competition has been adopted, the Netherlands arguably offers one of the best models of managed competition in practice. We also find the managed competition model has been relying heavily on regulation and less on competition to work. Any attempt to adopt the Dutch model of managed competition would then depend on how capable the sponsor/ regulator is in the country or region of adoption.

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[*]Author works with Dvara Research, India. Email ID: hasna.ashraf@dvara.com

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1 Background

The Dutch health system is characterised by high life expectancy, low DALY[1] rates, declining avoidable hospitalizations and low avoidable mortality compared to other high-income countries (IHME, 2019; Kroneman, 2016; WHO, 2020). It also has Out-of-pocket (OOP) payment levels well below the EU and OECD averages. The system also fares well in terms of customer satisfaction with its easy access to, and declining waiting times for, care. Dutch citizens rate both the quality of the health system and their health as good (Kroneman, 2016). The Netherlands has been able to achieve these outcomes through its private-first health system, an architecture reinforced by its landmark Health Insurance Act of 2006. Both purchasing and provision in the health system are managed by private entities that compete within a highly regulated system. The Netherlands thus offers a leading case of managed competition in practice.

In this paper, we look at what made a transition to managed competition possible in the Netherlands, how managed competition has played out, and the challenges that the system currently faces. Section 2 looks at the socio-political and economic context that led to the adoption of managed competition in the Netherlands. Section 3 describes the design of its current health system with a specific focus on the financing and regulatory architecture. Section 4 compares the practice of managed competition in the Netherlands against the theoretical principles laid down by Enthoven. Finally, Section 5 assesses the performance of the system and identifies key challenges faced.

2 The road to managed competition

The Dutch have prioritised local-level initiatives over state-led centralised interventions and this principle can be seen reflected in their constitution of 1848. This tenet can further be seen in how the Netherlands has historically approached social welfare. For instance, the Poor Law of 1854 which allowed for financial assistance for the destitute (including for healthcare), while allowing for public interventions in healthcare, considered such interventions as the last resort once all private sources had been exhausted, a case of private first-government last approach (Bertens & Vonk, 2020). This also came with a strong moral appeal to the social solidarity principles of Dutch society. The role of the government in financing healthcare was thus minimal, with the government opting to tackle very specific problems in healthcare financing through very specific measures. This had led to what Bertens & Vonk (2020) describe as a "layered" system of financial

[1]Disability Adjusted Life Years- 27979 compared to the OECD average of 29600

arrangements that is part direct government financing, part social health insurance(both mandatory and voluntary) and part private health insurance.

The balance that existed between its multiple parts was however disrupted in the 1970s with rising wages and the oil crisis of 1973 subsequently pushing up healthcare prices. This pushed the government to take greater control. While a case was being made for nationalised healthcare with centralised funding, this was not a viable solution because of the economic crisis at the time. In an attempt to restructure the system, the government removed voluntary social health insurance and elderly insurance and the beneficiaries were divided between social (both mandatory and voluntary) and private health insurance (voluntary). To ensure that the system offered *universal access*, the government introduced the ‘Minor system reform’ in 1986- a government-controlled standardised private health insurance policy, that acted as a ‘public option’. Collectively, these measures simplified the system, reduced the layering that existed and also brought in greater government control over private players.

In 1987, the first concrete step towards managed competition was laid by the Dekker committee report which proposed universal health insurance based on the principles of regulated competition. This would entail compulsory standard health insurance for all through private health insurers. However, the plan did not find many takers even among private insurers who considered this an extension of social health insurance. Notwithstanding the rejection of the proposed grand reform, the 1990s saw the gradual implementation of some of the measures detailed in the Dekker committee report (including greater consumer choice, community-rated premium and risk-adjusted capitation). These changes along with the implementation of the government-controlled standard insurance policy reduced the differences between social (sickness funds) and private health insurers.

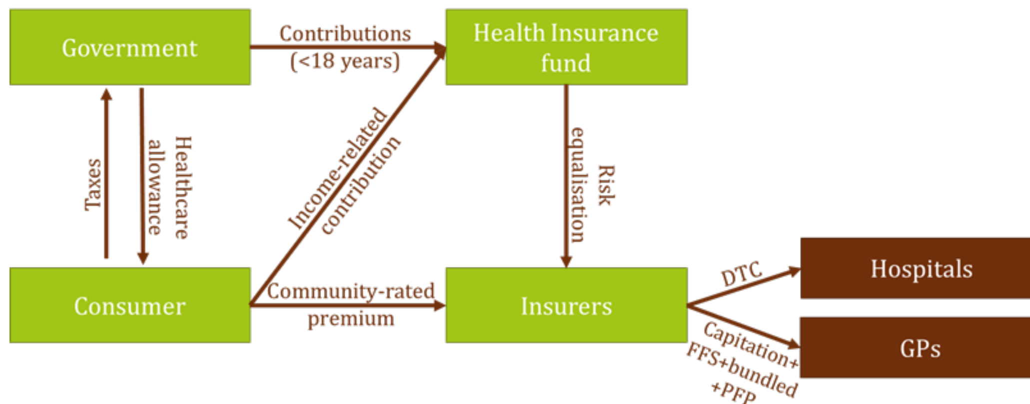
The dissatisfaction with the stringent supply-side cost control regulations of the 1970s and 80s and the gradual convergence between sickness funds and private insurers finally led to the adoption of managed competition in 2006 through the Health Insurance Act (Bertens & Vonk, 2020). The Act obligates every person in the Netherlands to buy individual health insurance (benefits specified by law) from private insurance companies. Failure to enrol can result in back payments for premium. Other key reforms under the Act included open enrolment and annual choice of insurer/ product, premium subsidies for the risky cohort through risk equalisation, general practitioners to serve as gatekeepers and selective contracting with providers (Enthoven & van de Ven, 2007). The key objectives of the reform were to promote efficiency, improve access at acceptable social costs and reduce

central governance (Kroneman, 2016).

3 Health system design

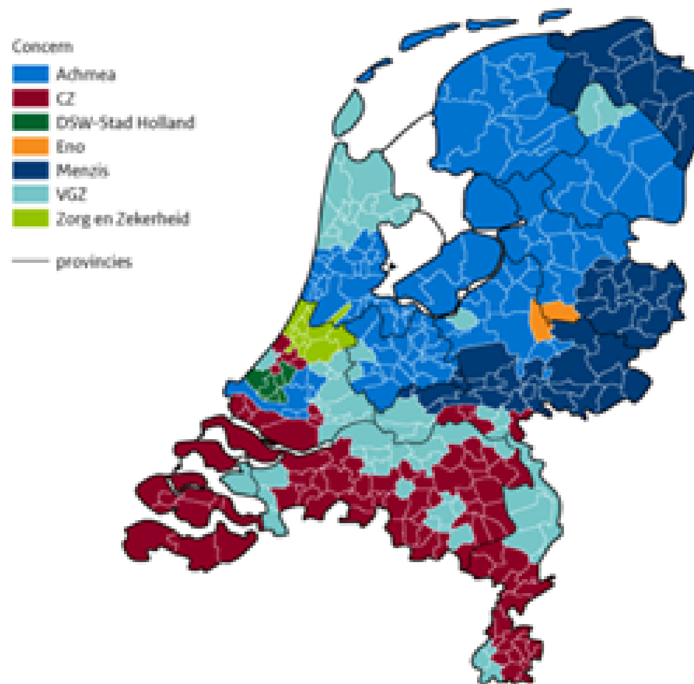
At present, healthcare in the Netherlands is primarily financed through compulsory health insurance. All above the age of 18 pay a community-rated premium to insurers of their choice. In case the community rated premium exceeds a proportion of household income, the government provides such households with a healthcare allowance. In 2007, nearly 2/3rds of all households received such an allowance (Enthoven & van de Ven, 2007). In addition to the community-rated premiums, they are also required to pay an income-dependent contribution to the central health insurance fund. For those below the age of 18, the government contributes on their behalf to the health insurance fund. Funds from the central health insurance fund are then distributed to insurers on a risk-adjusted basis (van Kleef et al., 2018).

Figure 1: Health system design- fund flow *(adapted from Van Kleef et al., 2018)*



Insurers then negotiate with providers primarily on the price of care. The contracts are not exclusive in that a provider can contract with multiple insurers. While the system allows for selection by insurers, in practice this has not been possible (Shmueli et al., 2015). One reason for this has been the ‘Care Fulfilment Law’ which mandates insurers to ensure that every customer has access to care within a reasonable time and distance (Victoor et al., 2012). Insurers are then required to contract with enough (if not all) providers in the regions where their customers are present. There are currently about 20 health insurers active in the market. These are part of larger health insurance concerns and there are 10 such concerns. The four largest concerns cover about 85% of the Dutch population (Vektis, 2021). Figure 2 shows the regional concentration of these concerns.

Figure 2: Largest health insurance concerns/ groups by municipality (as of 2021)



Source: Zorgverzekeraars accessed from
https://www.vzinfo.nl/zorgverzekering/regionaal-zorgverzekeraars as on 18-03-2022

Healthcare in the Netherlands is provided by independent non-profit entities (Kroneman, 2016). Access to hospital and speciality care has to pass through gatekeeping by GPs, midwives and dentists. While each consumer can approach only one assigned GP (Shmueli et al., 2015), when it comes to speciality care through referrals they have a relatively free choice of providers, such choice being constrained by the extent of reimbursement they may receive for a non-network hospital (Kroneman, 2016)[2]. Hospital organisations[3] are primarily paid through a form of diagnosis-related group (DRG) payments- Diagnosis Treatment Combinations (DTCs) (payments for a care path)[4] decided by the annual negotiations

[2]In the case of out-of-network hospitals insurers can charge copayments up to 50% of the average market price for a particular treatment (van Kleef et al., 2018). This is however limited in practice.

[3]Each of these hospital organisations also have outpatient specialist care tied to them and are often paid salaries. While the overall number of hospitals have been decreasing, such outpatients clinics have been increasing sharply (61 in 2009 to 141 in 2021) as more and more hospitals are opening outpatient clinics on the edge of their catchment areas to compare with other hospital organisations (VWS, n.d.-d)

[4]For instance, for a broken arm, instead of payment for each scan and diagnosis, the payment is for an average of all costs associated with this such cases as negotiated between insurers and

between providers and insurers.[5] GPs are paid through a combination of capitation, fee-for-service (set by the regulator), bundled payments for integrated care (negotiated with insurers) and pay-for-performance (Kroneman, 2016; Schut & Varkevisser, 2017).

The health system is regulated by the Dutch Health Authority or NZa, an independent administrative body that falls within the broad purview of the Ministry of Health, Welfare and Sport (VWS). The powers and responsibilities of the NZa are defined by the Healthcare Market Regulation Act, the Health Care Insurance Act and the Long-Term Health Care Act. A key responsibility of the NZa is to keep costs contained. Healthcare services are broadly divided into free and regulated sectors.[6] For those services under the regulated sector, NZa sets maximum rates based on periodic surveys it conducts, within which insurers and providers can negotiate. The NZa also sets the limits of the fee-for-service payments to GPs. Ensuring the compliance of all players involved in healthcare falls within the purview of NZa, making NZa the single regulator for both healthcare and insurance (NZa, 2019). This would entail, for instance, the responsibility to ensure that health insurers accept everyone for basic insurance, without selecting for age, income, lifestyle and state of health. Strong regulation through NZa thus forms the backbone of the current Dutch health system.

4 Principles of managed competition in practice

Enthoven (1993) defines managed competition as a "*purchasing strategy to obtain maximum value for consumers and employers, using rules for competition derived from microeconomic principles*". In describing the theoretical model, Enthoven details a set of principles that underlie the system. The Netherlands is often considered a prime example of managed competition in practice. In this section, we attempt to assess the extent to which Enthoven's principles hold in the Netherlands.

4.1 Tenets of managed care

Enthoven states that managed competition occurs "*at the level of integrated financing and delivery plans*" (Enthoven, 1993), in other words at 'managed care'

providers. There are 4400 such DTCs (Wammes et al., 2020)

[5]In practice, such a negotiation is based on the amounts and volumes in the previous year, within the maximum limit set by the Health Authority.

[6]The categorization of treatments into these groups is done by the Ministry of Health, Welfare and Sport and the Lower Chamber of Parliament.

levels. It is therefore critical to understand if and how the Dutch system has the essence of managed care. Given the wide variation of form that these principles manifest themselves in, it is often difficult to identify a single model of managed care. It may instead be understood as a continuum of financing methods that integrate care with financing following a set of basic tenets detailed below (Kongstvedt, 2013; Sekhri, 2000).

4.1.1 Managed care through non-exclusive contracts

As we have already noted, while insurers are free to contract with a select set of providers to offer a comprehensive integrated offering to customers, the contract between providers and insurers is not exclusive. Additionally, article 13 of the Health Insurance Act stipulates that insurers have to reimburse the cost of care (even if not fully) even when patients make use of non-contracted providers for care, further limiting the scope of selective contracting (Stolper et al., 2019). Insurers are, however, free to set up their healthcare facilities. Efforts towards such vertically integrated structures have been limited, but slowly growing (van Kleef et al., 2018).

4.1.2 Strong gatekeeping with a focus on prevention

Another element of such integrated managed care structures is gatekeeping and the provision of care at the appropriate level. As noted in the previous section, the Netherlands has a very active gatekeeping system. In terms of the scope of services provided, Dutch GPs are notable for their broad service profile. Nearly 93% of all patient contact is handled at the GP level, only 7% of consults result in a referral to further care. A GP typically caters to about 2,200 patients (Wammes et al., 2020).

The concept of managed care also emphasizes prevention. In the Netherlands, preventive care associated with chronic conditions is managed at the GP level. Broader preventive care is handled by GGD or the Regional Public Health Services. This broader preventive care, which includes vaccinations and infectious disease management among others, is paid for by tax revenues.

4.1.3 Incentive alignment efforts centred around GP

Yet another key element critical to managed care is incentive alignment between providers and insurers. In the Netherlands, while insurers are free to decide the provider payment design, there has been a reluctance to apply innovative payment models such as pay-for-performance for hospitals. Lack of sufficient information regarding the quality of outcomes is one major reason preventing this. We see greater innovation of payments at the GP level where a mix of payments is

used to incentivize providers. The base payment is composed of capitation and fee-for-service payments (accounting for 75-80% of earnings). GPs also receive a bundled payment towards multidisciplinary care for chronic patients and payments for infrastructure needed for multidisciplinary cooperation within primary care (accounting for 15% of earnings). They are also entitled to additional pay for performance and innovation (accounting for 5% of earnings) (Schut & Varkevisser, 2017).

4.2 Establishing rules of equity

Enthoven's principle of equity in healthcare envisions universal access to healthcare in terms of entitlement to the same basket of care and affordability of care.

4.2.1 Mandatory standard benefits package supplemented by a widespread voluntary cover

To ensure equal access to care the Netherlands offers a standard mandatory benefit package that all residents are entitled to. The benefits are decided by the government and currently include GP care, maternity care, hospital care, home nursing care, pharmaceutical care and mental healthcare (Kroneman, 2016). The standard package comes at a mandatory deductible of €385. The Netherlands however upholds the principle that primary care must be free at the point of delivery. Therefore, GP care along with obstetric and maternity care and dental care for those below 18 are among those services exempted from this deductible. In addition to the mandatory deductible, consumers can also opt for a voluntary deductible (of an additional €500) in exchange for lower premiums. In 2021, around 13% of Dutch citizens opted for this voluntary deductible (Vektis, 2021).

Customers can also choose to buy an additional insurance for those services not covered by the standard package, including physiotherapy and dental care. This is purely voluntary and need not be purchased from their mandatory cover provider. A vast majority of Dutch citizens purchase supplementary cover- as of 2021, 84.89% opted for supplementary insurance (Vektis, 2021).

4.2.2 Dual contribution and health allowances to ensure affordability

The Netherlands attempts to achieve both health equity and income equity through the two sets of contributions citizens must make. Health equity is effected through the community rated premium, a flat premium consumers are charged for the standard insurance plan by an insurer of their choice, regardless of their health status. Insurers are free to set the community-rated premium level. The average annual

premium comes to about €1471 (NZa, 2021). The Netherlands targets income equity through an income-dependent premium that is paid by employers on behalf of their employees to the tax office. These income-related contributions towards the health insurance fund allows risk equalization, indirectly making community-rated premiums possible.

To ensure affordability of the community-rated premium, the Netherlands offers a tax-funded health allowance. The quantum of this allowance depends on income. The maximum monthly benefit allowed in 2022 comes to €111 for singles and €211 for families (Zorgwijzer, 2022). In 2015, around 36% of the population received some allowance (Kroneman, 2016). Furthermore, as noted earlier, the premium for those below the age of 18 is paid by the government.

4.3 Selecting participating plans

According to this principle, the sponsor is responsible for choosing plans in the market on behalf of the consumers (Enthoven, 1993). Towards this, the sponsor (which is, in this case, the regulator-NZa) can create the conditions for consumers to make an informed choice. This can be through making simplified information available to facilitate comparison and identifying players that can participate in the market.

4.3.1 Comparative information freely available except for quality indicators

Comparative information on health plans is freely available through various websites. However, (Douven et al., 2017), note that such information often tends to be incomplete and sometimes biased by commercial interests.[7] A recent regulatory move in this direction requires health plans to publish the price of similar plans that are sold under different labels, in an attempt to make it easier for consumers to identify the cheapest plan (Douven et al., 2017).

The quality of contracted providers can also influence a consumer's choice of health plan if performance indicators are more readily observed (Van den Berg et al., 2008). Quality information on a set of indicators is available through public websites endorsed by the government, websites of health insurers and hospitals and publications in newspapers and magazines. While there have been considerable efforts towards improving the transparency on quality indicators of hospitals, current quality indicators available provide information only on the structure and

[7] When customers enrol to a plan through such comparison websites, they receive a brokers' fee. This can then potentially cause biases in how information is presented.

process of care and not the outcomes of care (Schut & Varkevisser, 2017; Shmueli et al., 2015).

4.4 Managing enrolment process

A key principle of managed competition is the active management of the enrolment process to ensure acceptance of all members by health plans and the allowance of switching between plans (Enthoven, 1993). This is critical for universal coverage and to ensure competition among the plans.

4.4.1 Universal acceptance for standard insurance

The Netherlands has a multiple-week open enrolment period in December each year when residents can choose their plan for the year. Universal acceptance is a core principle of the Dutch health system, guaranteed by law. Under the Health Insurance Act, insurers are obligated to accept all those who have applied for the standard package. This is, however, not the case with supplementary insurance. As citizens are not legally required to have a supplementary cover, insurers have no obligation to accept all applicants. They also have the freedom to set the premium and the cover provided in this case.

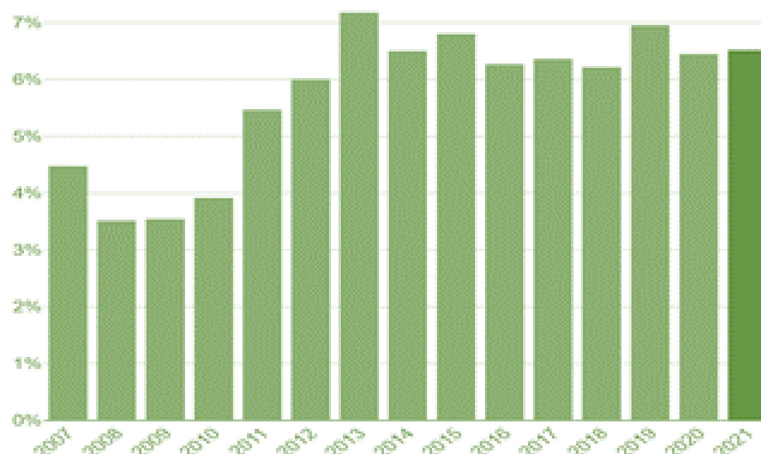
4.4.2 Switching rates remain constant across the years

Before 2006, the switching rate was between 2-4% a year. In the year of the reform, the switching rate shot up to an all-time high of 18% primarily driven by the greater consumer awareness regarding the possibility to switch (Douven et al., 2017). Switching rates have since dropped and have been fluctuating between 6-7% for years (figure 3). At the end of 2020, 6.5% of all insured persons switched plans.[8] Experts identify standard benefits packages and low variation in premium and network hospitals across plans as reasons for low switching rates (Mulder, 2022).

Switching trends vary across region, age, health status and enrolment in supplementary insurance. Most switchers in 2020 were from the central part of the country (VWS, n.d.-f). This seems to correspond with the fact that the region also has a higher number of insurers as well as hospital networks. Studies find that switching rates decrease with age and poor health status (Duijmelinck et al.,

[8] It should be noted that this figure does not include those who have switched as a result of a collective contract or those who switched from one package to another with the same health insurer.

Figure 3: Rate of switching across years



Source: Factsheet verzekerdenmobiliteit accessed from
https://www.vektis.nl/intelligence/publicaties/factsheet-verzekerdenmobiliteit as on 21-03-2022

2015; Duijmelinck & van de Ven, 2016; van der Schors et al., 2020). One unfortunate consequence of this has been that insurers have lesser incentives to invest in high-quality care for these customers with poorer health (Duijmelinck et al., 2015). Customers with supplementary insurance were also found to switch less often than consumers with one. This could potentially be due to such customers being more risk-averse and preferring to avoid the decision to switch (Holst et al., 2018).

4.5 Creating price elastic demand

A key function of the sponsor in a managed competition system is to create price elastic demand so that health plans are incentivised to compete on prices. Enthoven envisions the sponsor to do this through limited sponsor contributions[9], standardised benefits package, individual choice of plans, availability of quality information to consumers and disincentivising risk selection (Enthoven, 1993). The NZa provides for a standard benefits package. However, as noted previously, its success in providing quality information both about plans and providers has been

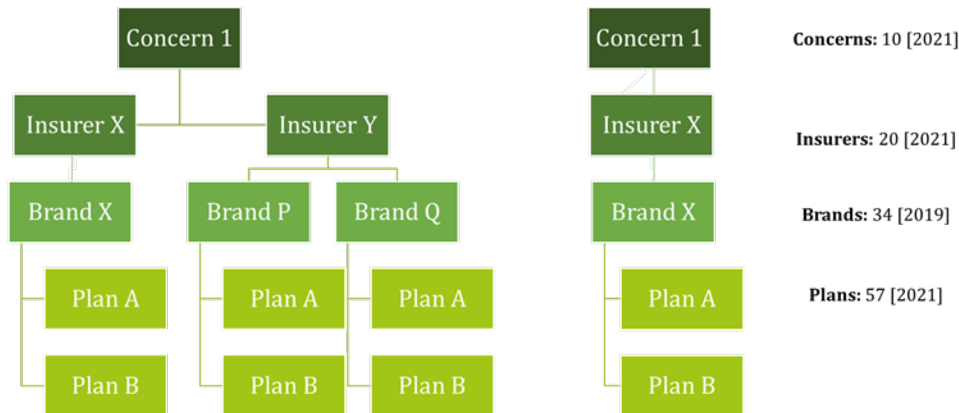
[9]Enthoven talked about this in instances where employer acted as the sponsor and a need was identified to limit the amount of employer contributions that can be tax-free to the employee. Since this is different from the system in the Netherlands, the notion of limited sponsor contributions has limited applicability.

limited.

4.5.1 Competition on price and supplementary package

The Netherlands currently has about 20 insurers[10] in operation, with these belonging to about 10 larger health insurance concerns. Many of these health insurers have multiple insurance brands[11], which offer a set of health insurance plans to consumers. For 2021, consumers could choose from among 57 health insurance plans (NZa, 2021) (Figure 4). These health plans could differ in terms of the level of voluntary deductible, the possibility of group arrangements, the network of contracted providers and out-of-network coverage (van Kleef et al., 2018). Comparison websites allow individuals to compare the different plans. Individuals can opt to enrol as individuals or through a group (employees of a firm, members of a sports club, etc.). Though the contract itself may be individual-based, insurers are allowed to offer specific pluses to groups. In 2015, nearly 75% of all insured were part of a group arrangement.

Figure 4: Supply structure *(adapted from Stolper et al., 2022)*



While the vision for managed competition in the Netherlands is for competition on price and quality, in the absence of quality indicators, competition on quality is yet to take off. The competition observed in the market (which is limited as indicated by the low switching rates) is on price. Official estimates note that price sensitivity in the market has been increasing. In 2021, with a 10% price increase in prices, the number of insured decreased by 14%, compared to 5% in the previous year

[10] Separate risk-bearing legal entities with an autonomous licence to operate (Stolper et al., 2022).

[11] Commercial identities without legal status. There were about 34such health insurance brands in 2019 (Stolper et al., 2022).

(NZa, 2021). Experts however note that the premium variation is not high for the standard package as the benefits are the same and insurers instead mostly compete on the supplementary/optional packages that the majority of Dutch citizens opt for (Mulder, 2022).

4.6 Managing risk selection

Yet another key responsibility for the sponsor as envisioned by Enthoven is managing risk selection. In a context where insurers are mandated to accept all applicants, risk adjustment becomes a key mechanism for insurers to be compensated for the additional risk they take on. Minimisation of risk selection hinges on the effectiveness of the risk adjustment mechanisms in place.

4.6.1 Evolving risk adjustment measures and persisting risk selection

The Dutch health system has one of the most sophisticated risk adjustment mechanisms currently in place. It has four different risk equalisation models (somatic health care, short-term mental health care, long-term mental health care and out-of-pocket payments due to mandatory deductibles). Each of these predicts the medical spending per individual based on which risk equalization payments are carried out (van Kleef et al., 2018). Risk is adjusted for age, gender, pharmacy-based cost groups (PCGs), diagnoses-based cost groups (DCGs), source of income, socio-economic status, region, etc. (Shmueli et al., 2015; van Kleef et al., 2018). The model has been undergoing continuous iteration to more accurately compensate insurers for their risks. Till 2016, the government shared risk with the insurers to reduce the effects of under- and over-compensation caused by the risk equalization model and reduce risks posed by types of spending outside the insurers' influence. The share of risk borne by insurers kept increasing as the risk equalization measures improved and eventually risk-sharing by the government was removed in 2016 (Stolper et al., 2022).

5 Health system performance and challenges faced

16 years have passed since the reforms of 2006 towards managed competition in the Netherlands. While it deviates in some ways from the theoretical model envisioned by Enthoven, the Dutch health system offers by far the most proximate model of managed competition. The Netherlands adopted managed competition with a set of objectives. This section looks at whether the Netherlands has been successful in achieving stated objectives through the reform and describes the challenges that continue to persist.

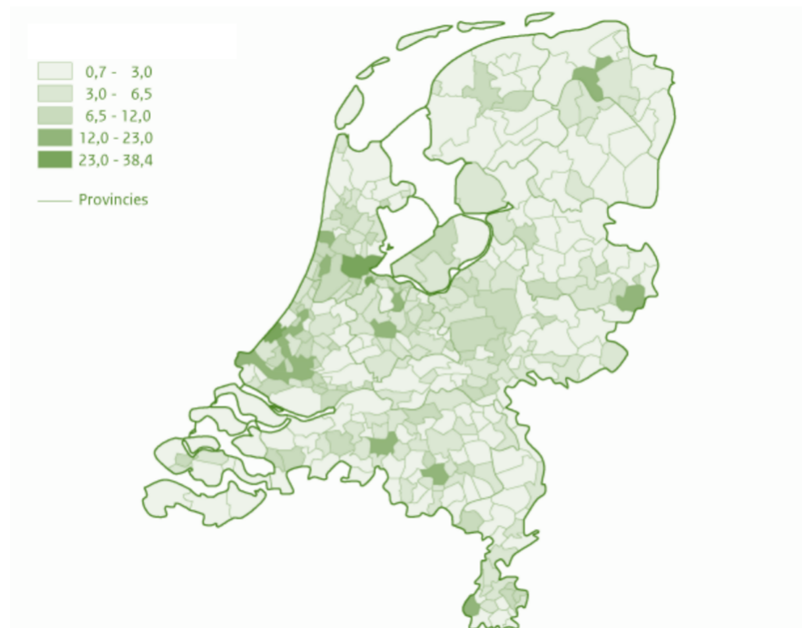
5.1 Performance

The 2006 reforms were aimed primarily towards improving access at acceptable costs and increasing the efficiency of the system through cost and quality control.

5.1.1 Steady improvements in access; ambiguous impact on affordability

In terms of physical access, while the number of hospital sites has remained stable since 2018, outpatient clinics have been increasing quite rapidly (Kroneman, 2016). This has primarily been led by hospitals' setting up such clinics at the edge of their catchment area to better compete with other hospitals. Similarly, the density of GPs has also been increasing over time- from 4.1 per 10,000 in 2013 to 4.4 in 2017 (VWS, n.d.-a).[12] Travel time to hospitals is also low. Rarely do the Dutch have to travel for more than 25 minutes to access care (VWS, n.d.-f).

Figure 5: GP Practices within 3 km per municipality (as of 2019)



Source: Huisartsenzorg accessed from https://www.vzinfo.nl/eerstelijnszorg/regionaal/huisartsenzorg as on 18-03-2022

[12]In addition to the regular assigned GPs that a patient ca visit during the daytime, a pool of GPs also serve at a primary care emergency centres at night, where a patient could get treated by any GP, making access to primary care available round the clock.

In terms of affordability, the mandatory deductible for the standard benefits package has been increasing over the years. From €150 in 2008, it increased to €385 in 2016 and has remained constant since. This subsequently also increased OOP payments. However, as noted previously, several key services including GP, obstetric and maternity care are exempt from the mandatory deductible. Additionally, health insurers may choose not to charge the deductible in an attempt to steer consumers towards contracted providers (Kroneman, 2016). However, to what extent this has led to a reduction of deductibles remains unclear. As the mandatory deductible increased, the period also saw a simultaneous increase of the health allowance that was transferred to the low-income segments to be able to pay for their premium and deductible. It should however be noted that despite these affordability measures, in 2020 nearly 7% of those above the age of 18 reported foregoing one or more forms of care (VWS, n.d.-b). OOP payments as a proportion of current health expenditure were at 10.6% in 2019 and has been on the decline since 2014 (WB, n.d.).[13]

5.1.2 Increased process efficiency but low impact on cost control

Efficiency would involve providing quality care through controlled costs. The density of physicians in the Netherlands has been increasing over the years (Kroneman, 2016). The number of beds at in-patient hospitals has been declining (by 16% between 2009-2018). This decline has partly been pegged to faster discharge from hospitals[14] and increased utilization of day treatment at out-patient clinics (VWS, n.d.-c).[15] Kroneman (2016) note that avoidable hospitalization for asthma, chronic obstructive pulmonary diseases and acute complications of diabetes mellitus are lower than what they are for other Western countries. This could indicate that primary health care and secondary outpatient care have largely been successful at controlling these ailments and preventing more serious symptoms from developing.

Waiting times for healthcare could be another indicator of efficiency and customer experience. Waiting times have been decreasing in the Netherlands (Kroneman, 2016). Healthcare providers and insurers have made agreements about the maximum acceptable waiting time in healthcare called Treek standards (about 4 weeks). As of 2021, waiting time is the highest for allergists (10.6 weeks), gastroenterologists (9 weeks) and the lowest for general surgeons (1.9 weeks) (VWS, n.d.-e).

The reforms were less effective when it came to cost control, another key efficiency

[13] After a period of steep rise between 2009-2013. However, in absolute terms, per capita OOP payments have been on the rise and was at $660PPP as of 2018 (WB, n.d.).

[14] Average clinical length of stay in 2019 was 5.2 days.

[15] Out-patient clinics have increased from 61 in 2008 to 144 in 2021

objective. The initial years after the 2006 reforms saw very little impact on national spending. The initial increase in spending has partially been attributed to the increase in utilization that followed the reforms (Stolper et al., 2019). However, with spending continuing to increase rapidly, the ministry reverted to regulator-enforced controls in 2012. NZa's expenditure caps for negotiations between insurers and providers are an example of these controls. Despite the initial success of these measures, the Netherlands continues to be one of the most expensive health systems in the world.

5.2 Challenges

In 2007, Enthoven and van de Ven noted that challenges facing the system included imperfect risk adjustment, the large scope for risk selection in supplementary insurance and the focus on insurers over delivery models. 16 years into the reforms, some of these continue to be the key challenges facing managed competition in the Netherlands.

5.2.1 Continuing risk selection

While the risk equalisation efforts have consistently been improving, insurers continue to be undercompensated for high risk and overcompensated for low-risk members for the standard package. This has led to continuing forms of risk selection and low incentives for investing in the quality of plans (van Kleef et al., 2018). The NZa has been monitoring risk selection through an analysis of switching rates and the extent to which profitable and unprofitable customers enrol with different insurers. van Kleef et al. (2018) note that even in 2016, insurers were under-compensated for high-risk and over-compensated for low-risk cohorts, leaving insurers with a tendency to risk-select. Since they could not legally reject applicants, targeted marketing was one way through which insurers tried to risk-select. Studies indicate that large insurer groups with different brands targeted their sub-brands towards the more profitable consumers. The more visible main brands targeted the broader spectrum of customers (Stolper et al., 2022). Studies also note that in addition to selective advertising and group arrangements insurers also adopted measures to deter high-risk enrollees through quality skimping (van Kleef et al., 2018). Additionally, accurate risk equalisation may also not be possible for all types of care, further exacerbating the problem.

While there are strong and continuously evolving efforts to contain risk selection in the case of the standard plan, there are no such efforts when it comes to supplementary insurance where insurers are free to operate as they see fit. With nearly 85% of the population opting for this additional cover, there is wide scope for risk

selection that supplementary insurance presents. Additionally, Kroneman (2016) noted that there has also been a shift of some benefits from the standard package to the supplementary package. Some of these include the first 20 sessions of physical therapy for people with chronic conditions, sleeping pills and tranquilizers, walkers and simple walking aids. This could then push even more people to opt for a supplementary cover.

5.2.2 Ineffective selective contracting

The reforms of 2006 called for the use of selective contracting of providers by insurers to encourage competition among providers. This, however, has been hampered by multiple factors. For one, the legal mandate requiring insurers to ensure accessibility of care, while improving access, has had the negative consequence of insurers inevitably having to contract with most hospitals. Additionally, article 13 of the Health Insurance Act stipulates that insurers have to pay a reimbursement even when patients make use of a non-contracted provider (Stolper et al., 2019). This further limits the potential for selective contracting. A 2014 bill that would free insurers from reimbursing non-contracted providers was voted against (Shmueli et al., 2015).

Apart from regulatory hurdles, the trust configuration in Dutch society that favours providers over insurers has also led to insurers' unwillingness to selectively contract with providers (Groenewegen et al., 2019; Shmueli et al., 2015). While GPs and hospitals are subject to the Dutch Competition Act, they have been fairly successful in preventing the enforcement of anti-trust regulations. The powerful lobbies providers are organised into along with the public support they enjoy has made this possible (Schut & Varkevisser, 2017). The resultant difference in bargaining power has led to, among others, substantive price variation between hospitals for the same products, and within a hospital for the same product across insurers (Douven et al., 2020). The lack of information on quality, further hampers insurer efforts to use quality indicators when contracting providers (Schut & Varkevisser, 2017).

5.2.3 Inability to control costs

While a key objective of the shift to regulated competition was cost control, as we have already seen, the competition was not effective in controlling costs. The system instead had to revert to more traditional regulation-centred measures to control costs. While OOP payments as a proportion of health spending are low, given the large expenditure levels at which the Dutch health system operates, absolute OOP payments can still be high for consumers. With 7% foregoing some

form of care, this continues to remain an issue that needs to be addressed.

6 Conclusion

Despite its limitations, the Netherlands arguably offers one of the best models of managed competition in practice that has been fairly successful in attaining good health outcomes and high levels of customer satisfaction. It should however be noted that in the Dutch application of managed competition, over the years the stress seems to be more on the "managed" part than on "competition". The system's effectiveness has been heavily reliant on the strong role that the NZa has played. Any attempt to adopt the Dutch model would also depend on how capable the sponsor/ regulator is in the country or region of adoption.

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